

Medicare Provider Instructions Credit Balance Reporting Requirements (FORM CMS-838)

Effective immediately, all providers of health care services participating in the Medicare program are required to submit a Medicare Credit Balance Report (Form CMS-838). A completed Form CMS-838 is to be submitted on a quarterly basis.

General

The Paperwork Burden Reduction Act of 1980 establishes the requirement that you be informed why information is collected and what the information is used for by the government.

Section 1866(a)(1)(C) of the Social Security Act (Act) requires hospitals and other health care providers participating in the Medicare program to make adequate provisions to refund any monies incorrectly paid. In accordance with sections 1815(a) and 1833(e) of the Act, the Secretary is authorized to request information from providers which is necessary to properly administer the Medicare program. In accordance with these provisions, Form CMS-838 must be completed by all hospitals and other health care facilities participating in the Medicare program to help assure that monies owed to the Medicare program are repaid in a timely manner.

The Form CMS-838 is specifically used to monitor the identification and recovery of “credit balances” due the Medicare program. A credit balance is defined as an improper or excess payment made to a provider as the result of patient billing or claims processing errors. For example, if a provider is paid twice for the same service (e.g., by Medicare and another insurer), then a refund must be made to the secondary payer.

For the purpose of completing the Form CMS-838, a Medicare credit balance is an amount determined to be refundable to the Medicare program. Generally, when a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient accounts receivable) as a “credit.” However, Medicare credit balances include money due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period (e.g., 90 days), and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies due to Medicare.

To assist in the determination of whether a refund is due the Medicare program, another insurer, the patient or beneficiary, refer to the following manual sections which pertain to the eligibility and Medicare Secondary Payer (MSP) admissions procedures:

- Sections 300 and 301 of the Medicare Hospital Manual;
- Sections 400 and 401 of the Medicare Skilled Nursing Facility Manual;
- Sections 300, 302, and 341 of the Medicare Home Health Agency Manual;
- Sections 250 and 300 of the Medicare Renal Dialysis Facility Manual;
- Sections 445-449 and 600 of Medicare Rural Health Clinic Manual;
- Sections 245-251, 300, and 302 of the Medicare Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual; and
- Sections 302 and 306 of the Medicare Christian Science Sanatorium Hospital Manual Supplement.

Submitting the Form CMS-838

Submit a Medicare Credit Balance Report to your intermediary (FI) within 30 days after the close of each calendar quarter. The report is to include all Medicare credit balances reflected in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances reflected in your records regardless of when they occurred. It is your responsibility to report and repay all improper or excess payments that you have received from the time you began participation in the Medicare program.

Completing the Form CMS-838

The Form CMS-838 consists of a certification page and a detail page. The certification page is to be signed and dated by an Officer or the Administrator of your facility. If no Medicare credit balances are reflected in your records for the reporting quarter, the certification page must still be signed and submitted attesting to this fact.

The detail page requires specific information on each credit balance, on a claim-by-claim basis. The detail page provides space to address 17 claims, but it may be reproduced as many times as necessary to accommodate all of the credit balances that are to be reported. The detail page(s) should be submitted on computer diskette. Attached is a formatted diskette, prepared in Lotus 1-2-3, for this purpose. (The certification page must be submitted in hard copy.)

Segregate credit balances attributable to Part A of the program from those attributable to Part B by reporting them on separate detail pages.

Complete the Form CMS-838 as follows:

Provide the information required in the heading area of the detail page(s).

- The full name of the facility;
- The facility's provider number; if there are multiple provider numbers for dedicated units within the facility (e.g., Psychiatric, Physical Medicine, and Rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- The Month, Day, and Year of the reporting quarter; e.g., 6/30/92;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (**when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim**):

- Column 1 - The last name and first initial of the Medicare beneficiary. (e.g., Doe, J.)
- Column 2 - The Medicare Health Insurance Claim number of the Medicare beneficiary.
- Column 3 - The 10-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.
- Column 4 - The 3-digit number delineating the type of bill; e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery, etc. Refer to Part III, section 3871 of the Medicare Intermediary Manual, or the Uniform Billing instructions of your manual (Hospital, SNF, HHA, etc.).
- Column 5/6 - The Month, Day, and Year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Indicate the Admission (From) and Discharge (Through) date using numerals (e.g., 01/01/91).

- Column 7 - The Month, Day, and Year (e.g., 01/01/91) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, the paid date and ICN number must correspond to the most recent payment.
- Column 8 - An “O” if the claim is for an open Medicare cost reporting period, or a “C” if the claim pertains to a closed cost reporting period. (An open cost report is one for which an NPR has not yet been issued. A cost report is not to be considered open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)
- Column 9 - The amount of the Medicare credit balance that was determined from your patient/accounting records.
- Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, Medicare credit balances should be repaid at the time the Form CMS-838 is submitted to your FI.)
- Column 11 - A “C” when a check is being submitted with the Form CMS-838 to repay the credit balance amount shown in column 9, or an “A” if an adjustment request is being submitted.
- Column 12 - The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if full payment is made.
- Column 13 - The reason for the Medicare credit balance by entering a “1” if it is the result of duplicate Medicare payments, a “2” for a primary payment by another insurer, or a “3” for “other reasons.”
- Column 14 - The Value Code to which the primary payment (Column 14) relates, using the appropriate two digit code as follows: **(This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer.)**
- 12 - Working Aged
 - 13 - End Stage Renal Disease
 - 14 - Auto No Fault/Liability
 - 15 - Workers' Compensation
 - 16 - Other Government Program
 - 41 - Black Lung
 - 42 - Veterans Administration
 - 43 - Disability

Column 15 - The name and address of the primary insurer identified in column 14.

NOTE: ONCE A CREDIT BALANCE IS REPORTED ON THE FORM CMS-838, IT IS NOT TO BE REPORTED ON A SUBSEQUENT PERIOD REPORT.

Payment of Amounts Owed Medicare

All amounts owed Medicare as shown in column 9 of the credit balance report should be paid at the time the Form CMS-838 is submitted (see Compliance with MSP Regulations below). Payment may be made by check or by the submission of adjustment requests. Adjustment requests may be submitted in hard copy or electronic format.

If a check is used to pay credit balances, adjustment requests must also be submitted for the individual credit balances that pertain to open cost reporting periods. Your FI will assure that monies are not collected twice.

If the amount owed Medicare is so large that immediate repayment would cause financial hardship, contact your FI regarding an extended repayment schedule.

Interest will be assessed on Medicare credit balances not timely repaid, in accordance with 42 CFR 405.376.

Records Supporting Form CMS-838 Data Submissions

Providers must develop and maintain documentation which shows that each patient record with a credit balance (transfer, holding account, etc.) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the Form CMS-838.

At a minimum, your procedures should: 1) identify whether or not the patient is an eligible Medicare beneficiary, 2) identify other liable insurers and the primary payer, and 3) adhere to applicable Medicare reimbursement rules.

Penalties may be imposed for failure to submit the Form CMS-838, or for not maintaining documentation that adequately supports the credit balance data reported to the Medicare program. Intermediaries will review a provider's documentation during their audits/reviews performed for cost report settlement purposes.

Provider Based Home Health Agencies

Provider based home health agencies are to submit their Form CMS-838 to their Regional Home Health Intermediary, even though it may be different from the intermediary servicing the parent facility.

Exception for Low Utilization Providers

Providers with extremely low Medicare utilization do not have to submit the Form CMS-838. Low utilization is defined as a provider that files a low utilization Medicare cost report as specified in PRM-1, section 2414.B, or files less than 25 Medicare claims per year.

Compliance with MSP Regulations

MSP regulations 42 CFR 489.20 require providers to reimburse Medicare within 60 days from the date they receive payment from another payer (primary to Medicare) for the same service. Submission of the Form CMS-838 and adherence to its instructions do not interfere with this rule; credit balances resulting from MSP payments must be repaid within the 60 day period.

Credit balances resulting from MSP payments must be reported on the Form CMS-838 if they have not been repaid by the last day of the reporting quarter. When an MSP credit balance is identified and repaid within a reporting quarter, in accordance with the 60 day requirement, it would not be included in the Form CMS-838; i.e., once payment is made a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the Form CMS-838 is due prior to the expiration of the 60 day requirement, it would be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form CMS-838 is submitted, but within the 60 days allowed.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0600. The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.